



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS RADIOLOGY
PO BOX 29490
SAN ANTONIO TEXAS 78229

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name

INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-05-2676-01

MFDR Date Received

December 8, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "While we were paid for the above date of service, 12/08/2003, was paid at a reduced Rate/Per Texas Mutual Explanation of Benefits [sic], payment for Procedures 76003, A4645 and A4647 were disallowed: reason given was 'The service listed under this procedure code are included in another more comprehensive code which accurately describes the entire procedure(s) performed'."

Amount in Dispute: \$271.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary taken from the table of disputed services: "Global to 25246. Global to 73222 incidental to 73222 – which includes contrast material."

Response Submitted by: Indemnity Insurance co of North

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2003	76003, A4645 and A4647	\$271.36	\$87.82

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, sets out the fee guidelines for professional medical services provided in the Texas workers' compensation system between August 1, 2003 and March 1, 2008.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 29, 2004 and June 1, 2004

- F – The services listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed.

Issues

1. Did the requestor bill for bundled procedures?
2. Did the requestor submit documentation to support fair and reasonable reimbursement for the unvalued codes?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for HCPC codes A4647 and A4645 and CPT code 76003 rendered on December 8, 2003.
2. Per 28 Texas Administrative Code §134.202 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.” CCI edits were run to determine if edit conflicts exist for date of service December 8, 2003. Review of the CCI edits finds:
 - Review of the EOB dated January 29, 2004 revealed the requestor billed for procedure codes: 25246, 76003-WP, 73222-TE, J2000, A4645, J3490 and A4647 rendered on December 8, 2003.
 - No CCI edit conflicts were identified.
 - The MDR will therefore review dispute procedure codes 76003, A4645 and A4647 according to the applicable guidelines.
3. Per 28 Texas Administrative Code §134.202 “(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection. Review of the submitted documentation finds that:
 - HCPC code A4647 is defined as “Supply of paramagnetic contrast material (e.g., gadolinium).”
 - HCPC code A4645 is defined as “Supply of low osmolar contrast material (200-299 mgs of iodine).”
 - Both the Medicare Fee Schedule and the Texas Medicaid Fee Schedule do not value HCPC codes A4647 and A4645; therefore reimbursement is subject to Rule 134.1.

Per 28 Texas Administrative Code §134.202 “(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.”

Division rule at 28 TAC §134.1 requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:

- The requestor billed HCPC codes A4647 and A4645 on December 8, 2003.
- The CPT code indicated above does not have a Medicare assigned value.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPC codes A4647 and A4645.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

4. Per 28 Texas Administrative Code §134.202 “(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%...” Review of the submitted documentation finds that:
- Requestor seeks reimbursement for CPT code 76003-WP.
 - The WP modifier identifies that the requestor rendered the professional and technical component of CPT code 76003.
 - The requestor submitted documentation to support that the services were rendered as billed.
 - Reimbursement is therefore recommended for CPT code 76003.
 - Reimbursement is calculated as follows: Medicare physician fee schedule amount \$70.26 x 125% = \$87.82.
 - This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$87.82.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$87.82 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06,, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 10, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.